

CITY OF SALINA
Potential Claims and/or Vehicle & Equipment Accident Report
Complete form and return to the
Office of Risk Management

Date of Incident:	Time (AM/PM):	Police Report Filed (Y/N):	Police Report #:

Department:	Employee Name:	Employee Position:
Employee Work Phone #:	Vehicle/Equipment Tag #:	Vehicle/Equipment Unit #:

Other Party Name:	Address (Street, City, State & Zip):	Phone Number:

Incident Location (List street address):

Incident Description:

Witnesses (If yes, please name & attach their written report):

Injuries (If yes, please provide their name and nature of injury, if known):

Department Head and/or Supervisor Comments/Suggestions:

Estimate of Damages:

Employee Signature	Date	Supervisor Signature	Date
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Supervisor Signature	Date	Supervisor Signature	Date
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Department Head Signature	Date
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